Chapter 8

Promoting Parent Readiness For Change: A Motivational Interviewing Approach

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In recent years, there have been many successful efforts made to treat behavior disturbance in children with intellectual disability by improving the parent-child relationship through parent education. Indeed, there are a number of well-evidenced programs designed specifically for the parents of children with intellectual disability. Social learning theory underpins the more successful of these programs. In many cases, teaching parents key strategies such as how to reward desirable behavior and not reward the unwanted, has the effect of reducing and preventing problem behaviour. While some families are highly motivated to participate in parent training and seem eager to apply the skills and strategies learned; others appear more reticent. Parent training programs do not typically address how to engage reluctant parents who may not be ready for change, and present as resistant. So, what should a clinician do? Engagement and participation are essential to successful treatment. Therefore, assessing parental readiness for change and enhancing parent education with strategies that improve motivation would seem useful.

Introduction

There is a large body of evidence to support the notion that parenting children with intellectual disability and behavioural disturbance is both complex and difficult (Hudson et al., 2003). Research confirms an inter-relationship between child behaviour, parent behaviour, and parental stress. Parents regularly report that increased stress is due primarily to the extent of child challenging behaviour, rather than the intellectual disability or reduced adaptive skills (Baker et al., 2003; Hastings & Beck, 2004; Beck, Hastings, Daley, & Stevenson, 2004; Plant & Sanders, 2007). The stress brought about by child behaviour in turn influences parenting behaviour, which further shapes child

behaviour. A higher level of parental stress is a key risk factor for the development of additional challenging behaviours and the exacerbation of existing difficulties (Baker et al., 2003). The relationship that exists between parental stress, parenting behaviour, and child behaviour is a potentially problematic one (Baker & Feinfield, 2007; Hastings & Beck, 2004). The imperative then is to interrupt this cycle by *engaging* the parent and *intervening* to break the cycle.

Parental Stressors

While many families are extremely resilient and adapt well to the demands of parenting a child with an intellectual disability, a child with accompanying social and emotional disturbance generates increased parental stress that is often chronic and persists over many years (Beck et al., 2004). Parental worry and strain has great potential to shape parenting behaviour and influence family relationships (Woolfson & Grant, 2006). Stress can lead to the development of unhelpful parenting behaviours that include rigid, coercive approaches that include punishment, or permissive parenting strategies that make few demands on the child and leave the parent with little control. Other parenting behaviours that typically lead to exacerbation of challenging behaviour include inconsistent discipline practices across the parenting team, a lack of inclusion of the child in family activities, and a lack of supervision. Stress may make it more difficult for parents to develop a warm, positive relationship with their child and encourage them towards independence.

The emergence of challenging behaviour, in addition to an intellectual disability, appears to fuel parental concerns about the impact of the child on siblings and other family members, on family cohesion, and on the family's sense of the child as a

member of their ‘unit’ (Llewellyn, Dunn, Fante, Turnbull, & Grace, 1999). Yet, attaining an adequate family quality of life is essential as it underpins the mental health and well being of children.

For some families, stressors directly associated with the extent of the challenging behaviour will be additional to others, such as marital conflict, a lack of extended family involvement, inadequate availability of advice and support, financial difficulties, and parental psychopathology (e.g., anxiety, depression, substance abuse). For some parents, their experiences of being parented, the pressure of parenting without a partner, changing family roles and relationships, cultural expectations, difficulties coordinating services, poor health, problem behaviour in siblings, and social isolation also influence their hopefulness regarding change and willingness to engage in intervention (Sanders, Mazzuccelli, & Studman, 2004).

Intervening to assist parents to change their behaviour can positively influence patterns and sequences of parent-child interactions that include or lead to behavioural difficulties (Rhodes, 2003). Relationships within a family, most importantly that between the child and parent, have a critical influence on the social, physical, and psychological development of the child.

Parental Engagement

Strategies underpinned by social learning theory and designed to improve the parent-child relationship have become the cornerstone in treating children with intellectual disability, and behavioural and emotional disturbance. One well-evidenced approach is parent education aimed at increasing parent skills and knowledge, and enhancing self belief (Sanders et al., 2004). These substantial, evidence-based programs are widely

used. Despite the many successes of these programs though, there are some parents and children who do not benefit. There is little information at hand regarding the engagement and subsequent involvement of families with children with an intellectual disability and behaviour disturbance. However, it is known that in other childhood populations, such as families with children with conduct problems, initial engagement is frequently difficult and intervention drop-out rates of between 25-50% have been found (Scott & Dadds, 2009).

Why are some parents more difficult to engage than others? Why do some parents appear so resistant? The clinician may attribute a lack of compliance with recommendations to a number of factors including:

- A lack of parental participation in formulating the treatment plan, i.e., the recommendations do not reflect the key priorities and concerns of the family or have not been developed in collaboration with the family;
- Parental doubt regarding the benefits and usefulness of the recommendations for the child;
- Difficulty with the recommendations because they are poorly matched to the child's developmental level;
- Reluctance to engage in services that involve outsiders knowing the family's business;
- The family's negative experiences with services in the past, related to their child with intellectual disability, or their own social history;
- A lack of insight about the future, i.e., a poor understanding of the risks associated with maintaining the current situation without action/intervention;

- Situational barriers, for example, the competing needs of siblings, work commitments of parents, parental use of alcohol and other drugs, lack of physical resources; and
- A mismatch between the intervention, and the parental beliefs and values (Hutchings & Lane, 2006).

Importantly, a lack of collaboration around describing the child and family's difficulties, goal-setting, and formulating interventions often leads to parental reservations regarding the plan. Patterson, DeBaryshe, and Ramsey (1990) suggested four factors that are likely to influence a parent's reluctance to engage in treatment, a) the parent's experience of interacting with their child, for example, some parents come to training with a history of many unsuccessful 'discipline confrontations'; b) pre-existing parental anxiety, depression, or other form of psychopathology; c) contextual factors such as social disadvantage; and d) the skill and intensity of the therapist's attempts to teach the parents.

Understanding And Managing Parental Reactions

There are a number of typical responses a parent might make when they are asked to change their behaviour as part of intervention: resistance, helplessness, and hopelessness; panic and anxiety; agreement without commitment; or relief and a decision to change. It is imperative that the clinician attempt to understand the parental response because the consequences of non-engagement and non-participation are significant. These include

- The family not receiving the necessary intervention;
- A more entrenched pattern of child behaviour;

- Maintenance of the cycle of unhelpful parenting, challenging behaviour, and stress; and
- A change in the clinician's behaviour, and subsequent reduction in the clinician's effectiveness (Patterson & Chamberlain, 1994).

It is necessary therefore, to have a planned approach to managing the process of initial engagement, and subsequent involvement of the family, as both are necessary for effective change.

Most intervention programs do not describe strategies for use when parents prove difficult to engage or when parents disregard the proposed intervention. So, what does a clinician do when they cannot get past the front door or treatment isn't utilised? Social learning theory remains most effective in parent training intervention, but ideas drawn from motivational interviewing practices may enrich the clinician's ability to help bring about change in families who are stuck. Motivational interviewing is well-suited to addressing the barriers described above, as well as a range of other issues the clinician may encounter when working with parents (Miller & Rollnick, 2002). Understanding the theoretical foundation of parent training is essential to good practice which will be addressed below.

Social learning theory states that attending to moment-to-moment interactions is critical: if a child receives an immediate reward for their behaviour, such as getting parental attention or approval, then they are more likely to do the behaviour again, whereas if they are ignored or 'penalised' for unwanted behaviour, then they are less likely to do it. To date, this has been the primary evidence-based approach (Scott & Dadds, 2009).

Patterson (1982) identified two main processes operating in families with children with disruptive behaviour. Firstly, parents model unwanted behaviour, so the child learns it too. Secondly, family process involves 'reinforcement traps', for example, a parent makes a request of a child, the child protests with unwanted behaviour such as aggression, and the parent then backs off. Thus, the child is learning that aggression can be useful in avoiding having to do something unpleasant and is more likely to do it again. Then, as the parent gets more and more angry/aggressive and, in this way gets the child to obey, they too are learning that aggression works (Scott & Dadds, 2009). In another common reinforcement trap, the more a child engages in undesirable behaviours, the less he/she will get rewarded for positive behaviours (Sanders, Mazzucelli, & Studman, 2003). Many efficacious behavioural interventions have focussed on this issue, including parent education programs (Scott & Dadds, 2009).

What Is Parent Education?

Research evidence verifies that parent education is useful in assisting the development of effective strategies for managing a variety of child behavioural difficulties. Positive effects of parent education have been noted and replicated many times across studies, investigators, and countries (Sanders, 1999). Parent education programs typically aim to do more than ameliorate the behavioural disturbance. Program intent often includes positive change to parental behaviour, knowledge, attitudes, and self efficacy; improvement in satisfaction of parents in their parenting roles; promotion of the child's cognitive development, pro-social behaviour, and health; promotion of the well-being of family members; enhancement of family relationships; and a reduction in the risk of

out-of-home placement (Kaminski, Valle, Filene, & Boyle, 2008). Thus for the clinician, increasing parental warmth and rewards for wanted behaviour, and setting clear limits and consequences for unwanted behaviour are essential. It is desirable to promote positive behaviour first so that the overall relationship improves before punishments are given (Sanders, et al 2004).

Assessing Parental Perceptions And Readiness For Change

It is imperative that any attempt to involve a family in parent education is preceded by a careful assessment. Behavioural disturbance is usually not the result of a single cause and requires a thorough clinical assessment. For the child, this requires the clinician include in their assessment the child's temperament, cognitive and emotional functioning, developmental and medical history, and behaviour. Assessment of parental and family factors is also essential, such as routines and living patterns, current strategies used to manage challenging behaviour, the goals of the family, access to and use of support services, parental problems, parental availability, cultural factors, the parent/child interaction, and the potential contextual fit of the parent education program. Matching assessment findings to the training approach is critical. Similarly, goal-setting and the measurement of outcomes should be reflective of the whole family, as well as the child (Wiese, Stancliffe, & Hemsley, 2005). Several well-evidenced parent education programs, designed specifically for the families of children with an intellectual disability, describe a robust process of initial assessment and ongoing monitoring (Sanders, 1999; Hudson et al., 2003; Sanders et al., 2004).

It is important that the clinician asks the parents about their *beliefs* regarding parenting, their hopes for intervention, the *importance* of making the change, their

readiness to change, and their *confidence* in making the change (Manchester, 2007). In order to do this, it is often useful to design a series of self-report measures so that the parent can rate their readiness for change or to comply with (jointly developed) treatment recommendations. Parental responses can be made on a likert scale, or 'change ruler' using a visual representation of a ruler marked from zero to ten. For example, parents can be asked to show their *readiness to change* on the ruler, with zero being very ambivalent about making changes, and ten being ready for change. The next step in the plan is based on the family's readiness for change.

The clinician may assess *importance* of changing by asking, for example, 'On a scale, how important is it for Natalie to sleep in her own bed?' Helping the parent list the pros and cons of the change can be an effective way of helping them identify the importance of the change and any barriers to change. *Confidence* can be assessed by asking, 'If you decided tomorrow that you were going to teach Natalie to sleep in her own bed, how confident are you that you could achieve this goal?' Using the scale can help the parent share more detail about readiness for change, confidence, and importance. If the parent is, for example, a 3 on a 10 point ruler, they are saying they think it *is a bit important* to increase their daughter's sleeping behaviour. The clinician could then ask, 'and why are you at a 3 and not at a 1 or 2?' An alternate question could be, 'What would it take to move to a 4 on the scale?' These questions help the parent state what is important to them about the change and suggests strategies they could use to achieve the change.

In the example above, a rating of 3 in importance is a sign that the parent is not ready for change. The clinician can acknowledge the parent's uncertainty and accept the lack of readiness to change. This does not mean, however, that the clinician does

nothing. Rather, the clinician helps the parent to explore *discrepancy* between desired goals and current behaviour (i.e., sleeping in the parent's bed versus sleeping in the child's own bed). The goal for the parent is to state the need to change in order to achieve the goal. This is known as *evoking change talk* which is designed to increase the likelihood that the parent will act on what has been discussed (Manchester, 2007).

What Might A Successful Intervention In Parenting Look Like?

Hutchings and Lane (2006) identified a number of actions that are important in 'engaging multi stressed, hard to reach families who have many other difficulties in their lives and feel blamed for their child's problems and abandoned by authorities/services' (p. 481). These actions include

a. Building a collaborative alliance with parents;
b. Mobilising parents' resources and working in a way that is compatible with their beliefs and values;
c. Empowering families to solve their own problems by building on existing strengths;
d. Accepting parents' goals at face value, tailoring tasks and suggestions to them, and collaborating in exploring material that is relevant to them; and
e. Conveying an attitude of hope and possibility without minimising the problem or the pain that accompanies it, that is, encouraging parents to focus on the present and future possibilities instead of past problems.

[Insert Figure 8.1 here]

A trans-theoretical model of the *Stages of Change* (see Figure 8.1) developed by Prochaska and DiClemente (1986), is a framework for understanding how people change behaviour and the theory underpinning Motivational Interviewing (DiClemente & Velasquez, 2002). The process begins at a stage of *pre-contemplation*, in which the family is not ready to change behaviour. Parents might have no problem recognising this and could appear, for example, resistant, reluctant, rebellious, or resigned. Readiness for change then moves toward *contemplation*, a stage during which the family is aware that a problem exists but is ambivalent about the need for change; from here, the family members move into *preparation and planning for action* in the near future. *Action* is where changes are made. *Maintenance* involves the family integrating changes and working to prevent 'slipping' or relapse. If a 'slip' or relapse occurs, the family is assisted to identify the problem, evoke 'change talk', and move on in a way that maintains parental confidence in their ability to make change.

Motivational interviewing is designed specifically to help clinicians work with people who are less ready to change (Miller & Rollnick, 2002). It can be used alongside parent training when engagement is proving difficult, or when parents actively resist proposed courses of action. Miller and Rollnick (2002) defined it as 'a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence' (p. 25).

There are a number of principles involved in motivational interviewing, as motivation is an interpersonal process open to influence and change. When using the motivational interviewing approach, clinicians move away from labelling and blaming parents, and move toward understanding the process of change. The clinician no longer considers parental denial, resistance, or lack of motivation (Prochaska et al., 1994).

When a clinician has identified a parent's stage of change, feedback can be provided to increase the parent's understanding of the need or potential for change. Parents, rather than the clinician, should identify the need for change and talk about how this change might happen. Motivational interviewing assists the parent's decision to change by facilitating reflective conversations. Clinicians facilitate reflective discussion by

- Expressing empathy;
- Exposing discrepancies between the parent's current reality and their desired goals;
- Avoiding arguments;
- Noticing resistance and viewing it as feedback that they need to change their strategies; and
- Supporting the parent's belief in his/her ability to change or create change (Miller & Rollnick, 2002).

Using motivational interviewing approach, the clinician acts as a partner in the process of change, not as an expert that tells parents about the necessity of change. Change talk is contrasted with resistance talk. The clinician is likely to elicit resistance by arguing for change, assuming the expert role, criticising, shaming or blaming, and labelling (Manchester, 2007).

One significant outcome of parental resistance is that it changes the behaviour of the clinician. Evidence suggests that these changes are likely to include

- A shift in the focus of the clinician's involvement *away* from social learning, *towards* managing the family;
- A subsequent increase in the number of sessions provided by the clinician in order to address social learning while managing resistance;

- A change in the clinician's efforts to teach and confront the parent. Sometimes the clinician will increase their efforts to teach and confront, hoping to force change (the outcome usually being further resistance); at other times, the clinician may become nondirective and unclear about what changes to family management practices are needed; and
- In response to high levels of resistance, a reduction in the interest of the clinician in trying to help the parent, described by Patterson and Chamberlain (1994) as 'the extinction of therapist caring behaviours' (p. 68).

Evidence suggests that a clinician can reasonably expect resistance at the initial to midpoints of intervention, yet resistance can occur at any point during a clinician's involvement. The nature of this resistance may change over time, as resistance is dynamic rather than static. A reduction of resistance is common when the parent is able to bring about positive change in the child, though this may require struggle, as their success provides strong reinforcement of any changes made to their parenting practices.

When Should Such An Approach Be Implemented?

Typically, this type of approach is useful when the clinician has little control of the situation. If the parent and child are engaged in treatment and participating, it is unlikely to be necessary. But the approach may be particularly helpful when the clinician has less control, such as in the initial engagement phase when the parent (or teacher or child) is doubtful about commencing treatment or accepting a view suggested by test results; or when a parent is dropping out of treatment because the clinician is getting increasingly coercive (e.g., trying desperately to get the parent to turn up on time or at all, to discipline the child) (Scott & Dadds, 2009). For example, take the situation where

both parents come in, each saying they have had a busy week and were not able to implement the programme, and when they gave it a try it didn't work anyway. If this pattern is repeated, it is time for the clinician to reflect and then go back and really listen to what the parents are trying to tell them.

Pulling It Together: A Case Study

The following case study demonstrates the potential usefulness of the Stages of Change Model (see Figure 8.1) in conceptualising readiness for change. It also shows how Motivational Interviewing (MI) techniques can be used to alleviate difficulties in engaging a parent in behaviour change. The case study is an example of working with a parent in the *Contemplation Stage*.

Background

Stephanie is the mother of a 10 year old girl. She reports being over-whelmed by her daughter's behaviours that include aggression towards others, minor property damage, and sleep disturbance. Stephanie has had contact with several agencies over most of her child's life. This involvement has included parent training, which she says was not helpful. Stephanie says she found it difficult to remember the appointments for training, difficult to understand the course content, and difficult to use anything she learned at home.

In response to a recent request for help with her daughter's behaviour, Stephanie was allocated a clinician and sat with them for several meetings providing information about her daughter and her behaviour. A month later, she was left with a copy of a lengthy behaviour assessment report and had difficulty understanding the relevance of

the material to her day-to-day problems. In post-assessment planning, the clinician advised Stephanie that intervention should focus initially on social skills training. This was a mismatch with Stephanie's beliefs about her daughter's behaviour. Stephanie has little confidence in her ability to bring about change and has little hope about the future being different.

Parental Reactions And Signs Of Resistance

- Passive agreement and acquiescence: 'Sure leave the report, I'll read it when I have time'.
- Disengagement: '… too tired, maybe another time'.
- Avoidance: Not home when clinician visits; re-schedules appoints into future – child sick, work commitment, and holidays.
- Changing the focus: 'I forgot that appointment'; 'I couldn't get there'; 'I had to work'; or, 'No, I haven't gone through the report, but let me tell you about his new teacher'.

Clinician Roadblocks To Listening

- Providing solutions: 'Social skills training has helped with a lot of other clients like your daughter. I would strongly recommend we start there'.
- The goals of the clinician were at odds with Stephanie's goals: The clinician reported to their clinical supervisor '… the visit went quite well. All the assessment items were covered with no problems'; 'I gave her the report and she seemed happy. I'll give her a call next week and get started, she is obviously ready'.
- Assumptions and labelling: 'Mum tends to be unreliable'; 'Mum won't take data'.

How Might A Motivational Interviewing Approach Help?

Using an MI approach, the clinician might express empathy, that is, discuss issues with Stephanie without judgement or criticism. In doing this, the clinician would check Stephanie's understanding, beliefs, and concerns using counselling micro-skills such as reflective listening and summarising of Stephanie's experience of parenting her daughter. Statements and questions that the clinician might have usefully used include

- 'You must be very tired after having your daughter tossing about in your bed last night, but you're here this morning. I'm thinking that perhaps, when you decide something is really important, you're willing to make a huge effort.'
- 'So what makes you think that it might be time for a change?'.

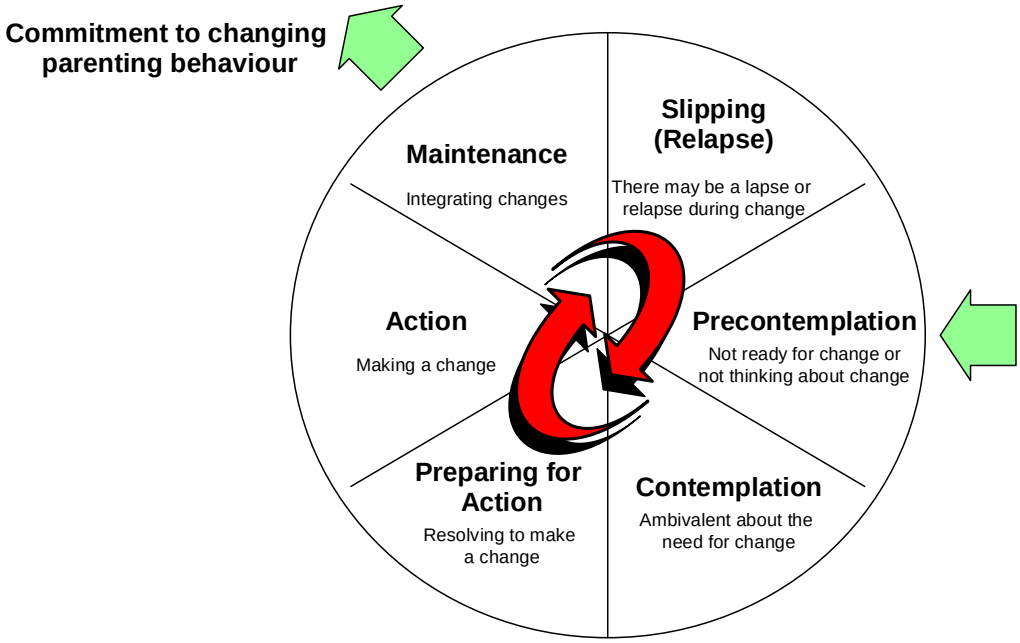
The clinician would consider whether there was any potential discrepancy between Stephanie's values and her parenting behaviour. For example, wanting her child to have good sleep habits, but allowing her to sleep in Stephanie's bed. When discrepancies become apparent, feedback about these differences can motivate a change in behaviour. In this instance, the clinician would not confront or accuse Stephanie of exacerbating the problem, but would help her move forward.

Resistance to change is seen as ambivalence in the contemplative stage. Ambivalence can help a clinician understand the mothers hopes and fears, and suggest how best to work with them. Here, the clinician would explore the pros and cons of change. They might explore the parent's best hope for change (his/her goals) by asking questions such as, 'If you were 100% successful in making the changes you want, what would be different? What would your life look like 6 months from now?'

For the clinician, working to evoke ‘change talk’, and build self-efficacy would remain a priority. Exploring Stephanie’s strengths and resources, as well as amplifying past successes, would support Stephanie’s self-belief. For example, Stephanie’s clinician might comment, ‘I can see you’ve had a lot on this week’, in response to Stephanie’s news that she hasn’t had time to read the report. Changing a parent’s perception of their own performance and capacities from negative to positive is critical in this process.

Figure 8.1

Stages Of Change



Source: Adapted from Prochaska and DiClemente (1986).